S. No. 2
—11-10-39
5-17-39
P I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17064

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 4542

1. PLACE OF DEATH:

(a) County
(b) City or town St Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 2 12

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County
(c) City or town St Louis 22
(If outside city or town limits, write "RURAL")
(d) Street No. 2709 A Eugenia
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Narcissis [redacted] McFadden

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female
5. Color or race Negro
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Ed McFadden
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 6 (Month) 3 (Day) 1897 (Year)

8. AGE: Years 42 Months 11 Days 18 If less than one day hr. min.

9. Birthplace Washington, Ark. (City, town, or county) (State or foreign country)
10. Usual occupation House Work
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Nelline McFadden
(b) Address 2709 A Eugenia
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27-40 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cemetery
18. (a) Signature of funeral director [illegible]
(b) Address 3103 Washington
19. (a) MAY 22 1940 (Date received by local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 21 year 1940 hour 1:55 minute A M.

21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Endocarditis; Coronary Sclerosis; Cor Bovis. — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other)
Address [illegible] Date signed

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Robert H. Powell.

Licensed Embalmer No. 3402

P. O. Address 3100 Franklin

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.